DOCUMENT RESUME

ED 351 168 RC 018 846

AUTHOR Bert, Cynthia Rowntree Greene; Bert, Minnie
TITLE The Native American: An Exceptionality in Education and Counseling.
INSTITUTION Independent Native American Development Corp. of Florida, Miami.
PUB DATE [92]
NOTE 64p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS American Indian Culture; *American Indian Education; American Indians; Classroom Techniques; *Cognitive Style; *Counseling; *Cultural Differences; Elementary Secondary Education; Learning Disabilities; *Special Education; Substance Abuse; *Vocational Education
IDENTIFIERS *Native Americans

ABSTRACT

Aimed at professionals and community members interested in program development, this paper presents an overview of issues in Native American education and counseling. A section on culture discusses similarities among Native world views and social behavior that are at odds with White values and behaviors. A section on Native American education points out the bias of schools that ignore Native attitudes and learning styles, and makes suggestions for culturally relevant teaching methods, evaluation methods, and classroom techniques. A section on special education discusses three methods of teaching content reading that have been successful among Native Americans with reading difficulties, problems related to differences among government agencies in definitions of learning disabilities, and the mistaken identification among Indian children of learning disabilities that are actually learning style differences. Other sections focus on vocational education and counseling; the importance for job success of task-related social behaviors, communications skills, and decision-making skills; dropouts; substance abuse among Native American youth, dysfunctional behaviors, and dysfunctional families; and individual, group, and family counseling for Native American substance abusers. This paper contains 63 references. (SV)

The Native American: An Exceptionality In Education and Counseling

Cynthia Rowntree Greene Bert M. Ed.

Minnie Bert

Independent Native American

Development Corporation of Florida

P.O. Box 654154

Miami, Florida 33265

(305) 551-2835

Contents

1. Introduction

In order to properly address counseling or education for Native Americans and for the professionals who will interact with them a personal awareness is necessary. It is important to know one's own theoretical orientation and cultural affiliation. It is also important to understand the Native American culture which is often diametrically opposed to other society systems.

Native American society has been forced out of balance. Individuals feel out of control of their own lives. Economically women are more employable in job markets of tribes on reservations in isolated areas. Traditional income practices for males are often under strict government control and are therefore limited. Emotionally individuals are isolated from others in the community. It is very difficult to define what is wrong, and to talk about it is impossible. Individuals young and old suffer in silence or seek quick cures to the pain. When an individual is intoxicated emotions spill out and life appears easier.

Many children are raised in homes where sometimes parents are sober and working, sometimes parents are drunk and fighting and there are no clothes or food. One does not know when one wakes up which day it will be. Mentally children receive no individual support for their "strengths" or discipline for their "weaknesses." They have little

individual self concept. The traditional group cultural adhesiveness is not encouraged for many families. Children have poor group self concept. They learn to blame others for their problems, but like all children want magically perfect lives. They see more and more of White societies' values through movies and T.V. The White dream is an advertiser's paradise. Reality is a wrestling match or a macho hero kicking expletives out of mass groups of people. There is no way to attain what they are told they must have. There is no "better" lifestyle than pain and loneliness so children drink, too, or they look for someone to hold them, and they don't care how they are held. Then children began to have children. This is what White professionals on reservations see.

It is hoped that the collection and dissemination of current research, program developments and cultural information will be useful for both professionals and community members interested in developing effective relevant programs for the Native American. Everyone involved in the community must contribute their expertise and broaden their knowledge to address the multifaceted problems of the present and to plan for the future.

"Today the Native American is the fastest growing ethnic group in the United States" (Ashabrammer 1984).

2. Culture

"One measure of whether a person's behavior is acceptable in a culture is whether that person is able to be competent in everyday life in that culture" (Brislin 1977).

Native Americans have been affected by legal and political policies which have constantly threatened their existence. From the forced reservation policies, the subtle and often overt goal has been to annihilate the Native American - or at least to assimilate the Native American into White Society. Time after time tribes which were thought to have vanished have reappeared. The time has passed for the majority culture to attempt to destroy or subjugate the Native American culture (Herring 1989).

Native American children are separated from other children in most educational systems by culture and ethnicity. Traditional Native American Attitudes are deeply and historically ingrained. When structuring counseling or educational programs either on or off the reservation certain cultural points must be remembered. All American Indian Tribes are separate but share some of the same similarities. A Native American identifies first with his clan, then with his tribe and then as an Indian. A Native American, his culture and his religion are the same. They cannot be broken into separate identities as they are intertwining

systems inseparable from each other (Herring 1989, Loftin 1989).

Clans within tribes have certain rites, traditions and myths which they preserve, however there is a commonality in the Tribes. There are also some similarities between the tribes' viewpoints: 1) All tribes believe in a harmonious (balanced) universe where everything has a sacred life. They share certain religious symbols such as earth, sky, water, stone and fire and also use common rites such as dancing, singing, smoking the pipe and most have sweats. 2) The belief that humans are part of and not superior to the whole of nature. To all tribes there is a spiritual character to the land. "Our land, our religion, our life are one." 3) Every individual has rights and deserves dignity and respect. 4) The individual is part of the whole group and is subjugative to the good of the group's existence. 5) Leadership is based on ability and earned respect (Tooker 1983, Loftin 1989).

Legal, political, economic and educational America has adopted the Puritan values of individualism, competitiveness, profit, speed and efficiency. Native Americans generally do not want to become like Anglo Americans. They do not want to exchange cultures. Herring (1989) documents an increase in historic knowledge and cultural pride among Native American Youth. Their cultural values differ

considerably from the values of White American culture. This results in stress while interacting in Non Native American life. For Native Americans truth is mythological. For Whites it is logical. Reality is spiritual for Traditional Native Americans. For White society reality is material. Whites respect the power of human politics. Native Americans respect the power of the world that creates and sustains them.

Native America has a cultural definition of social behavior which should be considered in social situations. For example Native Americans are present oriented and lack training in time consciousness which makes scheduling difficult for them. This may appear as deviant, but is a relevant and normal cultural phenomenon. Native merican cultural and heretical practices should not be devalued by White professionals who are often culturally chauvinistic. They should admit their biases and proceed in a non derogatory manner. Throughout history Whites have elevated themselves over others by negative definitions of "savages" and "primitives."

Native American culture does not increase a child's self concept in the same manner as other cultures. Some Native American concepts are in direct opposition to activities used in education and counseling. Positive self talk and individual competition are not traditional for Native

Americans where cooperation and harmony in the group are valued. Native Americans consider it ill mannered to speak of one's own accomplishments. So strong is the value of co-operation within a group that being identified as better or worse than other children is extremely stressful to an Indian child (Mitchum 1989).

Eye contact is expected in White social interactions. For Native American children eye contact signifies disrespect. The Native American culture also values reticence. Lack of verbal participation in a group setting may cause Indian children to seem unknowledgeable or unwilling to participate (Youngman, Sadongi 1974).

It is important to most Native Americans to be able to survive in both worlds, however, they want to learn White skills while retaining culture and tradition. They resist absorption because assimilation - whether it is voluntary or involuntary - still makes a Native American White in spirit.

3. Native American Education

3.1 Present Reality

"Little difference exists in the level of self concept between preschool Native American and White children" (Bruneau 1985). "However when Native American children enter school this changes" (Soldier 1985).

Native American traditional education was performed outside of school classrooms in the natural environment where natural qualities which the child was familiar with were used to teach about life and living. Learning was very right hemisphere oriented with techniques which used learning by doing, symbols, dreams and humor. Traditional education allows learning by discovery (Herring 1989).

True cultural insight allows looking beyond differences to the integrity of the individual. It prevents misinterpretation of behaviors which do not follow an accustomed pattern. Cooperative children who do not compete with their peers are see as non-motivated. When Native American children err their elders demonstrate correct behavior privately and quietly. There is little scolding. Not many teachers do that. When adults yell children loose respect because the adults cannot control their tempers. Negative results, from cultural insensibility in education, include inadequate challenges and expectations from teachers and counselors. Children have been continually tracked into low levels in public schools and labeled in public and reservation schools (Gabe, Fuqua, Hurlburt 1984).

The present reward system for all students in public schools and most reservation schools is based on White concepts and values. Native Americans have different learning styles which are seldom taken into consideration. Children

feel disrespect and begin to feel hopeless, helpless and alienated (Goodlad 1983).

English texts teaching strange skills with distorted information about history is taught mostly by Whites through non native language. This teaching is initiated and perpetrated by culturally biased standardized tests. This system offers little hope of alternative possibilities (Gay 1983).

3.2 Learning Styles

"Culture is a variable not a deficiency to be remedied" (Loftin 1989).

People perceive everything differently according to their own approach to learning and the variables of their family, peers and culture. Native Americans have traditional styles of learning which differ from the styles used in most American school systems. These styles may cause misconceptions regarding ability by educators. Native Americans learn slowly by observation and private practice. They do not jump into a task or perform it publicly until it is mastered. Mental competence must precede physical activity. Traditionally multisensory approaches have been used when elders teach young people. Native American children feel comfortable when time is taken to complete their understanding of the total picture about what is expected and how

to accomplish that expectation. They learn this by observation preceding performance. When teachers question, often a Native American student will not respond; however, when a teacher makes an observation or comment the children are more likely to respond and join into a discussion. The Native American child enjoys experiential learning. They cooperate well in the group setting, however, they are not competitive if it sets them above the group. They hesitate to perform individually in groups unless the groups are led by students or an adult they can relate to culturally as an elder. Most Native American children learn best by observation, careful listening, supervised participation and individualized self correction. There are more ways of demonstrating acquisition of knowledge than by recitation or by questioning. Learning must be a cooperative effort. An individual's humility is something to be respected and preserved. Native American children are taught not to parade their knowledge or to try to appear to be better than their peers. However, where performance is socially defined as benefitting the peer society, Native Americans become excellent competitors. This is why Native Americans excel at team athletics (Swisher, Deyhle 1989).

For Native Americans who continue in education the expectations to succeed creates extreme performance anxiety. As education progresses the type of writing required becomes

impersonal and analytical. For many individuals who see everything in a subjective way this becomes another source of anxiety. That is compounded by an increased need for technical vocabulary.

Exams in the form of true-false or multiple choice prove to be difficult. These types of questions require only memory for details and neglect synthesizing ability. By contrast essay exams, which require more effort and preparation are often perceived as easier. These questions require a synthesizing of understanding and an ability to interrelate main ideas. Many Native Americans find knowledge as it is acquired and expressed flowing together connecting by contrast or compliment to each other.

Study schedules are best if systematic and organized. Studying should be done in one place using multi modalities. Material should be read and paraphrased in students' own writing. Native American students often report "seeing" their answers to exam questions on their note papers. The act of writing appears to be important and the actual discussion with oneself outloud or with a study partner is seen as an excellent way of memorizing.

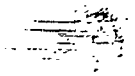
Native American students who continue in education who have difficulties with lectures and readings may suffer from transitional language and vocabulary problems and lack of opportunity to practice these skills using professional

academic language. This should be ascertained prior to attributing deficits in this area to cerebral or sensory preference. Most American Indian Tribes have rich literary and oral traditions requiring substantial linguistic skills.

Native Americans in graduate school use theory to tie together the practical knowledge previously acquired. Everything seems to connect itself to reservation life and is examined as appropriate and applicable for Native American culture complex concepts and elaborate theories attach themselves to concrete memories becoming more comprehensible and memorable. This indicates the higher order ability to critically evaluate and analyze a particular concept while maintaining a subjective accepting perspective. This also indicates the ability to synthesize extensive diverse information.

Native Americans have the ability to try on new ideas from the inside out and to evaluate them from a subjective, pragmatic perspective. Individuals are open to accept or reject parts of ideas and adapt them to be more personal or culturally relevant or they may reject them altogether. This is ingrained respect for the world outside the self and a recognition of the potential for the knowledge and insight which may be gained from others.

Empathic, participatory listening in silence is an important part of Indian oral tradition. Traditional belief

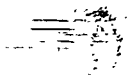


dictates that an accepting subjective stance is imperative for full understanding. This is the attitude required for learning from Indian symbolism and mythopoetic speech. Strong oral traditions predispose most tribes to listen intently to both elders and teachers in a non-demonstrative, introspective way, experiencing what they hear. This is followed by private reflection.

Native American children have been found to do well on tasks requiring synthesis of complex information or integration of varied stimuli, but they do not perform so well on tasks requiring rote memory. It is important for educators to make teaching meaningful and relevant for these skills. Organizational techniques such as "mapping" and "networking" and holistic language are excellent for this (Macras, 1989).

3.3 Needs

Verbal presentations should be supplemented with alternative modes of teaching. Learning can be demonstrated in alternative interactions. Teachers should build classroom flexibility slowly using multisensory instruction. 1) Teachers should assess students' methods of learning in various situations. 2) Conceptual goals or skills should be taught in the students' style of learning. 3) Use continual observation for determining attainment of knowledge and degree of student involvement. 4) Slowly add the required



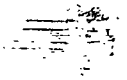
behaviors which the students avoid. Always clarify the goal, the materials necessary and the task requirements. Use what the student is comfortable with to support new experiences.

Teachers should also help the student understand why they do what they do by discussing their learning styles with them. It is imperative that teachers be aware of Native American culture and experiences and that they themselves should be flexible in adapting teaching to the students' learning style. Students in Native American culture have little time framework. They do not like to be spotlighted. They need time to practice privately before performing publicly. Students need to participate in activities which encourage both independence and cooperation. They need to become aware that their academic mastery will benefit the group. This must be accomplished without raising the student above the other members of the group. Teachers must provide group feedback but must provide independent feedback in private. This feedback must be immediate, consistent and descriptive (Swisher, Deyhle 1989).

4. Exceptional Education and the Native American

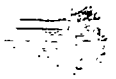
4.1 Similarities of Populations

There are two popular theories about why children cannot read. 1) There is an inefficient decoding of words. 2)



There is no cognitive strategy for remembering and comprehending material.

When teachers deal with rates of processing prose they are focusing on lower level reading processes such as decoding, leaving little to apply toward higher order mental processes necessary for comprehension. The reader, working alone, must attend to small meaningless visual processing units (i.e., individual letters) placing heavy demands on attending process and short term memory. Variations in abilities and effective uses of self regulatory processes complicate the problem so that teachers tend to "instruct" students individually with busywork which is irrelevant and not based in anything concrete. This situation produces many referrals among Native American students for learning disabilities testing. There is a high percentage of this population which is staffed into special education programs. In most Native American special education programs it has been shown that three methods of teaching content strategies are successful, especially in group situations. These strategies involve predicting content, formulating questions while reading, and summarizing or paraphrasing the material. This allows the child with lower decoding rates to know what to look for and expect. It provides a concrete reference to attach individual words to (Ellis, Graver 1990).



Because problems associated with specific learning disabilities and other handicapping conditions began in childhood and continue into adult life there is a need for continuing services between agencies which service Native American children who have acquired these labels. Usually these agencies utilize guidelines and definitions that enable persons to continue services in a straightforward and timely manner. However in certain areas, specifically in "learning disabilities," debates over theoretically sound and meaningful definitions have persisted for many years (Biller, White 1989).

In 1985 State Vocational Rehabilitation Agencies converted specific learning disabilities to a neuropsychological classification code so that, like mental retardation, a psychologically based determination rather than a medically based diagnosis is all that is required for placement and services. The Rehabilitation Services Administration, however, still stresses a neurological derivation. This involves a diagnosis of involvement in the central nervous system. The United States Office of Education, in public law 94-142 defines specific learning disabilities using the term psychological, not central nervous system. The A.C.L.D. defines specific learning disabilities as being of presumed neurological origin involving the central nervous system.

The Rehabilitation Services Administration defines specific learning disabilities with inclusions referring to social competence and emotional maturity. The United States Office of Education makes no mention of social competence and emotional maturity. The A.C.L.D. definition does include these social and emotional components. The school system tends to label students with social and emotional problems as "emotionally handicapped." Most Native American schools attribute emotional and social problems to situations and environments which the student interacts with. Therefore, there are few students labeled "emotionally handicapped" and many labeled "learning disabled."

It appears that idiosyncratic differences, often hard to detect in some individuals, when paired with the demands of school, family, peers or other environments requiring social or academic skills, manifest themselves in subaverage performance patterns. Academic deficits are an important component of definitions, however, intelligence appears only in the A.C.L.D. definition.

If one examines the deficits in the learning disabilities definitions there are other differences which can be seen. In rehabilitation deficits are operationalized by deficits in 1) academics 2) neurological deficits 3) perception 4) language. Deficits in special education are operationalized 1) academic 2) discrepancy 3) exclusion.

Professionals must begin to communicate about these differences and common points in the definitions so that services may be provided and continued as needed (Biller, White 1989).

4.3 Needs

There is so much discrepancy between labeling definitions and between children with problems that it is important to take a second look at educational programs. A Native American child brings three determinates of learning to the classroom. These are maturation, life experiences and interactions with others in other environments and the student's own psychological and phisiological biology. Any one of these components and factors can contribute to a temporary or permanent learning disability.

Native American children have many strengths in their learning styles, however, these styles are contrary to methods used in regular White traditional classroom or teaching styles. The types of learning situations best suited for Native Americans are those used in exceptional education classrooms - particularly those labeled Learning Disabilities. Many new programs based on the Wholistic Languages Programs recently introduced in the United States work well with Native Americans, due to the matched style of instruction, the building on the student's strengths and the

emphasis on increased verbal and experiential skills simultaneously. It appears that in the future emphasis on Native American education must differentiate between style of learning and learning disability. There are obvious and logical interventions which must be defined and attempted prior to labeling a Native American student. There are obviously successful programs which should be learned properly by professionals and implemented in Native American classrooms to support the learning styles and increase the learning rate of these children.

5. Vocational Education

5.1 Present Reality

"The present vocational development for Native Americans is unfulfilled dreams, wasted potential, dashed hopes and economic struggle. Career myths which do not compliment Native American opportunities or abilities are prevalent. Counseling does not address this misfortune in most systems. This results in limited employment possibilities due to lack of skills in today's technical specialized society" (Herring 1989).

By the year 2,000, there will be three major trends in employment in the United States. 1) Higher levels of academic skill will be required. 2) Service industries will increase while factory jobs will decline. 3) The work force

will change demographically. More older workers, women, minorities and immigrants will be at a distinct disadvantage if not trained (Brown 1989).

5.2 Goals

It is imperative that Native American communities began to search for Vocational Education funds and programs. Job opportunities related to the training programs and business opportunities should be explored and encouraged for reservation residents. Students who are learning academic skills should be jointly trained at early stages in vocational skills. As monies are cut from programs, tribes will need to form coops to supplement this important area. There should be constant attention to this matter from the funding sources. It is far better to fund a vocational/work program than to attempt to expand social welfare programs in the future to encompass all the needs that will arise.

5.3 Strategies

If an individual has mastered job-required skills social competence becomes the indicator of occupational adjustment and vocational success. The social skills required for competency are of three types: 1) Task related behaviors 2) social communications skills and 3) decision making skills. Task related skills involve following directions,

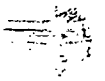
staying on task, attending, volunteering and completing tasks. Social communications skills include greetings, conversing, listening, smiling, laughing and complimenting others. The skills needed for decision making are accurate perception of personal or social situation and effective choices of behaviors (Cartledge 1989). These behaviors are necessary for following directions and accepting criticism from authority figures, dealing with co-workers, participating in job interviews, self assessment and making career choices. Social skills may be taught individually and in groups. They must be practiced repeatedly to promote generalization.

In special education it has been found that when the only target of teaching intervention is the student, then transfer and generalization of learned skills does not happen between the special classroom and mainstream classrooms. However, when classroom teachers are also taught as part of the intervention process then results are more promising. Similarly, when employers and "special" employees (both those with handicaps, minorities and others newly trained) are both part of a job orientation process, the success rate increases for both job performance and length of employment. Services need to be provided for longer periods of time than most vocational agencies allow for. People with special handicaps and newly learned skills need specific, on going

as needed services such as groups for peer support and individual and group practice on appropriate social and work related behaviors. Specific areas which need reinforcing practice include accepting criticism; dealing with authority; evaluating one's own performance; goal setting and long range vocational planning; developing social skills; and making appropriate decisions. Employers need to learn how to define job expectations; provide constructive feedback; accept input from employees; and to be flexible about differences in employees while maintaining standards of expectations about job performance (Michaels 1989).

An important aspect in counseling or teaching an exceptional population is to include vocational counseling as part of a case management system. The role of the rehabilitation counselor is fourfold. 1) To restore, replace, or compensate for missing assets and skills. 2) To integrate a positive self image. 3) To formulate realistic goals. 4) To construct a facilitative work environment. A counselor must be a counselor, a coordinator and a consultant for the family, the school, potential employers and the community at large (Hershenson 1990).

There have been successful school based intervention programs which use acquired social skills to increase resistance to pressure to use substances. These decision making skills are also necessary for job performance and in social,



professional, and health related situations. Native American youth have poor job performance records. They have a high rate of health compromising behaviors with death as a common by-product of these behaviors. When students are taught a four step decision making process and can apply this to social, job related or health problems their ability to handle situations increases. The four step process involves: 1) Defining the problem. 2) Identifying courses of action. 3) Thinking through the effects of each choice. 4) Making a decision and acting on it.

When teaching a decision making process the situations used should be culturally relevant and comprehensible to Native American youth. References orally and in writing to reservations, pow wows, cultural activities or jobs they are familiar with make generalization of the decision process more likely to occur. Teaching may include slides or film if available, but must include instruction and teacher modeling, question and answer sessions, role playing, small group activities and written exercises. Students should be able to identify several options ar the costs or benefits that go with each. They need to practice these skills and the process involved in choices (Ohweemabua 1989A).

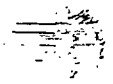
It appears there is a transition in children's thinking where they shift from basing their decisions on the health or business consequences of behavior (i.e., becoming ill or

being fired as a result of one's behavior to focusing on the social consequences of behavior (i.e., not being accepted by one's peer group or co-workers as a result of one's behavior). This transition takes place between eleven and thirteen years of age making them respond differently to social or other problems (Okwren, Abrea et al 1989).

Children, according to Inhalder and Piaget (1964) go through three stages of cognitive development from preoperational (3-6 years) through concrete operational (7-11 years) to formal operational (12 + years). There are limitations to the kinds of strategies children at various cognitive levels are capable of manifesting. The formal operational child is capable of differentiating between self and the environment and considering multiple alternatives in decision making situations.

The use of chemicals retards social and emotional development. The age at which a person starts to use substances is the age at which development stops. The ability to make friends, communicate effectively, behave normally, to feel good naturally, to learn stops. Cognitive development stops.

In a study on problem solving appraisal and techniques, middle aged adult male alcoholics were found to have abilities close to those of adolescent males. These men also overappraised their abilities so that there was little con-



gruence between appraisal and ability. Increased emotional and psychological pathology will accompany increased levels of substance abuse (Larson, Heppner 1989).

There are many factors to consider in developing a Vocation Educational program for Native Americans, included in these are cultural considerations, developmental level, learning style, health considerations, familial situations, realistic expectations and opportunities, and skills needed. Due to the complexity of factors a case management system is recommended for each student client.

5.4 Dropout Populations

A major area vocational education has to deal with is that of school dropouts. High rates of school dropout contribute to disadvantages both individually and for the community. School dropouts have lower status occupations, tend to participate less in social institutions such as voting or interest in tribal affairs, they also have lower personal income. They create the need for more costly employment or training programs. Dropouts may also involve higher rates of adolescent problems such as delinquency and substance abuse. Adolescents leave school because of pregnancy, economic necessity and other reasons. Minority dropout rates are higher per population. There are many reasons students drop out. When families do not support education or the

achievement of educational skills students often drop out. When a student's peers are dropouts the student often follows. Family systems, peer systems and the educational system produce social, psycholcgical and belief expectation systems inside a child. When social controls are weak deviant behavior results. When moral bonds are inappropriate or missing, antisocial behavior occurs. There seem to be four elements to dropout behavior: attachment, commitment, involvement and beliefs. These change as the external or internal environment of the child changes. Deviant behavior is both a predictor and a result of the interactions between a child and his external world. There are multiple paths which lead to dropout and often other behaviors such as delinquency and substance use. These span the range of social, personal and cultural problems. Focusing exclusively on one area such as strengthening school ties or reinvolvement in a vocational rehabilitation program may overlook contributing factors in other relationships. Even students without learning problems or problem behaviors may leave school for many reasons. In order to really intervene schools, voc ed programs and counseling programs must become the center for both education and social activities for the children, their peers and their families. This should be done including and considering respectfully the cultural aspects of the child (Fagan, Pabon 1990).

6. Substance Abuse in Native American Youth

6.1 Present Reality

"Alcohol related deaths are the leading cause of adolescent deaths. This is the only age group for which the death rate is increasing rather than decreasing" (National Council on Alcoholism 1982).

"Suicide is the number one cause of death between the ages of fifteen to nineteen years for Native American youth" (Herring 1989).

Students who bear labels classifying them as exceptional or handicapped often show symptoms which reflect central nervous system dysfunction. These same behaviors are also reflected by people who are using drugs or alcohol. The central nervous system consists of systems within systems within systems interlocking, built on columns and modules of neurons. Dysfunctional behaviors include attention deficits, delayed maturation, memory deficits, and poor psychomotor skills (Gilkeson 1989). It is important to include professional consultation in this area for case managers. Individuals need to be evaluated for medical intervention. They also need to be evaluated when their problems interfere with education or life functioning to determine if substance use may be causing or contributing to the situation. Poor learning and inappropriate behavior may be the result of poor teaching, learning disability, or substance use.

Before education can begin substance use must stop (Fox Forbing 1991).

Individuals experience great variability in genetic and biochemical makeup. Lifestyles also affect the body internally and externally. Some individuals may be born with excesses or deficiencies of neurotransmitters, neurohormones or receptor sites (Tennant 1985). Depressant chemicals including alcohol, marijuana and heroin lower catecholamine activity, decrease brain arousal and impair brain functioning. Stimulants such as cocaine and amphetamines deplete catecholamine transmitters, neurotransmitters, dopamine, norepinephrine and serotonin (Cooper, Bloom and Roth 1982).

Children with attentional deficits have been found to be deficit in norpinephrine which results in neurotransmitter flooding of the motor cortex resulting in hyperactivity (Tennant 1987). Fox and Forbing suggest that because some students diagnosed as learning disabled are deficient biochemically they are more vulnerable to any and all of the drugs which directly affect the neurological system. They state that studies show fifty percent of alcoholic men were classified as hyperactive children. They also suggest that individuals with poor self concept and poor self discipline are more susceptible to peer pressure. Peer pressure is a leading cause of substance experimentation.

Children of alcoholics are at high risk for substance abuse. This may be the result of genetic influences as well as a coping mechanism for life situations. Genetic influences of alcohol or substance use may also result in learning or behavior problems. Many Native American children exhibit signs of alcohol syndrome. More children are being born addicted to crack cocaine (Fox, Forbing 1991). These children who have been prenatally exposed to substances exhibit a wide range of characteristics and problems. Children have immature nervous systems. Exposure to substances prior to age twenty increases vulnerability to addiction.

For young children indirect experiences such as parental modeling, peer modeling and media dissemination of cultural values probably constitutes a child's primary sources of learning about alcohol and other substance use. Because adolescent drinking set the pattern for adult drinking it is important to be able to flag high risk children for prevention programs (Christiansen, Roehling, Smith, Goldman, 1989).

For Native American children all are at risk. Somewhere in every family is a problem. The most frequent health compromising decision making situations confronting most of these children involves parents or older adult relatives. Native American culture demands respect toward el-

ders without challenge or refuting instructions. There is little transportation available on a reservation. Any ride, even with a drunk driver, is apparently better than no ride. Substance use and the causes thereof and resultant interventions should involve the entire community. This would create a more positive and lasting impact on culturally rooted behavior which is more resilient to change even when that behavior has become deviant from the way tradition meant it to be. Modification is easier when adults or elders are involved in the process (Okwamabua 1989A).

Addiction and dysfunctional family life are reciprocal. One produces the other which affects the first producing more dysfunction. These behaviors and addictions are often passed from one generation to another (Lewis 1989). Adult behavior produces feelings in children which reduce self concept. Substances, however they are introduce to the child at this point, alleviate the painful feelings and are continued to dependency levels through "self medication" (Bradhshan 1988).

Lewis (1989) documents that in treating adolescents families must be included. The person using substances is playing a role in the family scenario by responding to, perpetrating or intervening in the interactions of the other family members. In treating the family as a unit in therapy interpersonal relationships may be explored, evaluated and

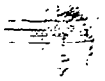
intervened with as needed to rectify or produce understanding of the behavior of those involved.

Most people who are treated for substance use will have an unstable recovery. Many variables affect each individual such as age, education, sex, living environment, etc. There are combinations of socioculture, situational and biological factors. Posttreatment Individual plans must consider and manipulate these factors in order to prolong the effects of treatment and to reduce the risk of relapse (Svanum, McAdoo 1989).

6.2 Needs

If the tradition and values of Native Americans are to survive, this problem, however painful, must be addressed. In order to begin the problem must be addressed through meaningful research.

Research can provide valuable insight into etiology, prevention, treatment and epidemiology. Research can guide policy and practice to improve the quality of life for Native Americans. However, research must have guidelines when being done in the Native American community. It must be undertaken as a collaborative effort in which the community is a participant in framework decisions. The community must grow to become the researchers of their own needs and interests. Research, if properly done, has the power to in-

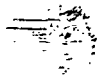


crease a Native American community's independence and self determination ability. The community becomes more conscious and able to differentiate its problems and causes. It learns its strengths and ways to define and face its problems (Mohatt 1989).

Mohatt goes on to explain that the community and researchers must become colleagues. The community must set the ground rules for research, including defining the purpose of the study, who controls the data gathered, the uses of the data and how and where it will be reported to the rest of society. The research team must include technical researchers, a broadly represented steering committee from throughout the community, and local research colleagues and workers. The team must continually check its progress against the desires of the community as originally stated. The community steering committee should represent all ages, sexes, clans and/or political beliefs. It is to implement and determine the implications and interpretations of the research study for the community's sense of well being and reputation as well as to seriously utilize the results to improve situations.

7. Counseling - A Three Pronged Approach

"Alcoholism and substance abuse is a highly complex disorder which can best be treated through a multidisci-



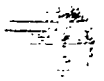
plinary approach which provides flexible, individual and group treatment for the multidimensional personalities and problems involved in the addiction" (Taricone et al 1989).

"Native Americans who have strong commitments to Native American cultures prefer professionals who are respectful of their culture, directive and nurturing. Native Americans who have strong commitments to Anglo American cultures as indicated by less tribal participation and lesser native language participation have less expectations from professionals" (Mitchum 1989).

7.1 Individual Counseling

Individuals and their environments interact and both are changed by the interaction. Some call the structuring of the environments ecological. The term case management is used here because the processes are similar. These include: 1) What is needed. List what is to be taught or changed. 2) How should this need be manipulated (instruction, intervention, etc.). 3) How will the individual be best motivated to complete the transition from one situational state to another.

Native Americans are an exceptionally homogeneous populations with diverse characteristics. Any case management system must be able to address a continuum of diverse situations and individuals. Environmental and physical factors



interact to determine the severity of the need. When relating case management to an ecosystem framework such as that discussed by Szymanski, Dunn and Parker (1989) these points must be remembered:

1) Each individual is part of many different environments such as school/work, family, friends, subexceptionality groups, etc. Interventions cannot address just one environment.

2) Individuals behave differently in each environment depending upon their self concept and own individualities and the demands and expectations of that environment.

3) Individuals and the environment must be active participants for change. Objectives must be clearly defined and understood, successes must be identified and measured and intercommunicational clarity must always be maintained. Individuals must help plan intervention strategies. Any aspect which is observable and measurable must have this documentation. The perceptual factors of individuals and environments must also be considered and described as much as possible. Discrepancies in an individual's perceptions must be addressed as part of the rehabilitative process.

4) Individuals have many interacting systems within themselves. If one of these systems is not functioning properly then the entire interactive process is disturbed. These systems must be evaluated medically to determine if

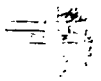
there may be problems internally. It is important for professionals in one field to communicate with professionals in other fields to stay abreast of current research and medical/scientific findings. These include psychologists, counselors, neurologists, neuropsychologists, educators, rehabilitations centers, and other helping professionals.

An individual's character is a function of central nervous system - physiological components which are complex interactions of the learned and innate. Character is the center of awareness of one's actions. An individual's personality is how the person appears to the outside world. This is an information "output" which is generated by character.

McCue (1989) lists several types of assessment which counselors may find of benefit. It must be remembered that when working with Native Americans' cultural bias may exist in the testing situations. Culture must always be considered when evaluating test results.

1) Psychoeducational Assessments: any of the Wechsler Intelligence Scales.

2) Physiological/Neuropsychological Assessment: Halstead-Reitnan Neuropsychological Battery; M.M.P.I. or Minnesota Multiphasic Personality Inventory (Hathaway, McKingley 1943).



3) Medical/Neurological Evaluations: Electroencephalograms; Computerized Tomography Scans; examinations for diagnosable central nervous system dysfunctions.

4) Vocational Assessments: Aptitute tests; academic grade placement (for G.E.D.); psychomotor tests.

5) Social/Interpersonal Assessment: Checksheets such as the EPSI (Erickson, Psychosocial Scale; Rosenthal et al 1981); self observation scales, family and personal histories.

In discussing counseling and Native Americans it is important to discuss personality deficits in substance abusers. These deficits may include depression, anxiety and hostility. The degrees of successful resolution appears to be associated with favorable changes in a person's environmental support system in terms of family, job, etc., and with the individuals' use of strategies to maintain sobriety. In addition to standardized group treatment formats individualized counseling must be done depending upon an individual's personality. All personalities of substance users are unfavorable levels of psychological distress. Tests show high correlations between normal personality characteristics during prolonged period of sobriety and opposite personality characteristics displayed under the influences of substances. These bipolar personality characteristics lie along the same psychological dimensions.

Substance use may allow escape for either an overcontrol of emotions, an overreliance on internal sources of stimulation, an overinterpretation of events in a very concrete literal way. Subjective discomfort and depression have been found to be as important a factor for some individuals' use as impulsive behaviors are for others. In this way normal adaptive personality traits have distinctive maladaptive counterparts (Kunce, Newton 1989).

Kunce and Newton found that using M.M.P.I. profiles persons with "extroversion/change" traits become "impulsive" drinkers in adults or "neurotic acting out" in adolescents. They relate substances to sensation seeking behaviors. They physically like the dizzy heights. Persons with "introversion/change" traits become "bright/unrealistic" drinkers in adults and "neurotic anxiety" diagnosed in adolescents. Substances for these individuals reduce worry and anxiety "introvertive/stability traits" become "guilty drinkers" adults and "manipulator" adolescents when substances are used as an inappropriate means for coping with an overcontrol of tension and depression. "Extrovert/stability" traits become "passive-dependant" in adults and "immature conformist" in adolescents. This personality uses substances to excess as a consequence of peer pressures arising from strong affiliation and conformity needs.

Treatment activities should be specifically designed to assist a person to find ways of meeting needs which are not consistent or compatible with his or her normal personality attributes. For example, many people who fall into the "introvert/stability" traits are normally reserved, modest, autonomous, introspective, and oriented to reality. Under substance use their pathologic personalities become depressive, compulsive, self-critical, tense, and socially alienating. They express expectations that substances will release emotions and inhibitions. These people will need alternative acceptable means of releasing feelings.

Counselors need to use a complex model of personality types to help with organizing individuals and affecting group counseling as well as to help in understanding dynamics in the individuals' relationships in other environments of family, peers, job, etc. This continues to support the view that deviant behaviors are biopsychosocial processes.

7.2 Group or Peer Counseling

Social skills training has been found to be a necessary intervention for problems such as vocational success, drug abuse, delinquency, mental illness and teenage pregnancy. This shows solutions to stressful situations which increase the likelihood of deviant behavior. It is important that after social skills are learned they generalize from one

situation to another. This would include social interactions and health threatening behaviors. Skills must also be maintained by constant practice. Social skills which can be taught include drug refusal, avoidance skills, problem analysis and problem solving, social and stress coping skills, discrimination situations, disappointing interchanges with significant others, slips into substance use, personal high risk situations, and depression. The most effective means of training these skills is through roll playing situations which may be encountered with authorities, peers, family and the opposite sex at work, school, home, in social situations or around the community. The main failure of social skills training results from performance deficits or an unresponsive environment which does not elicit positive reinforcement (Hawkins, Catalano, Gillmore, Wells 1989). Social skills may be taught individually and in groups. Follow up groups need to meet on a regular basis.

Because the Native American culture places more value on group contribution than on individual success, group work is the most logical mode of delivery for educational or counseling services. Group format may reflect aspects of the group and its work rather than focus on the individuals within the group. Self concept will mirror group culture and pride. Similarities and group members' common strengths and interests may be explored. A group personality will

emerge and the Native American concept of strong group unity will be preserved. If the group is challenged to change in some area and does, individual self concept improves as part of the group's strengthening (Herring 1989).

7.3 Family

"A substantial portion of depressed patients either drop out of therapy or do not recover. There is little evidence to support the positive effects of therapy on depressed patients or benefits over time to prevent recurrence. It has been postulated that recurrence rates would be reduced if family relationships were to improve" (Jacobson et al 1989).

Before a discussion on counseling intervention in dysfunctional family relationships it is wise to describe what a healthy family interaction looks like. All families have some strengths and resources to build on. All families bring experiences and skills to a learning situation. All families have some idea of what their goals and behaviors should be.

Lee and Goddard (1989) described some strong family characteristics which functional families share:

1) Functional families spend time together and are involved in each other's lives. They care about and support

other family members' projects and activities outside and inside the home.

2) In functional families boundaries are clearly set. Decisions and rules are explained. There is maintained balance between limits and flexibility.

3) Functional families are local and united. There is a family sense of pride and a strong sense of family history.

4) Functional families share common values and have a religious orientation. They share moral values, spiritual goals and expectations.

5) Functional families have an emotional closeness and support each other in emotional ways. They provide and express positive feelings about each other. They appreciate, affirm, trust and support each other. There is a common individual respect for similarities and differences in the other members.

6) Functional families communicate. Dialog is open and clear. They are not deliberately unkind to each other. Members are allowed to speak for themselves. They are allowed successes and failures. Members do not blame each other.

7) Functional families encourage responsibility. There are techniques for coping and problem solving which work and which are taught to children. Problems are met

head on and dealt with. There is strong individual belief in self and the ability of other members.

8) Children in functional families are allowed to develop into unique personalities. There is a preparation for future growth and respect from all members.

A loving, nurturing relationship with parents can show children how to care, give and compromise in relationships with others. Rejected children tend to distrust and attribute malevolent motives to others resulting in a defensive aggressive approach to peer interactions. Some rejecting parents are nearly indifferent to their children while others adopt a harsh aggressive parenting style. This provides modeling of aggressive noncomplient behavior to influence another person's behavior. Parental rejection also affects an adolescent's sense of self confidence and self esteem. Parental drinking contributes to inconsistent parenting and impacts upon a child's mode of coping by modeling a deviant strategy for dealing with stress and tension. When children adopt deviant behaviors, socially adequate peers reject them. They then drift into associations with one another in deviant peer groups. Often they use substances to deal with their feelings of inadequacy, aggressive peers and rejecting parents.

Rejecting parents also fail to provide value instruction. Value commitments to work, education and friends are

non existent. Children lack a feeling of value about themselves. Because these children have only an avoidance coping style they are at great risk for substance use.

Individual counseling should focus on children's deficient social skills and coping strategies. Children need to develop a less coercive, more cooperative interpersonal style. Any progress toward changing these social skills and coping strategies is likely to be undermined unless family counseling is successful in altering parent-child relationships. Family therapy should be concerned with redefining members' boundaries and roles and with establishing constructive communication patterns. Counseling should also teach parenting skills and model nurturance (Simons, Robertson 1989).

In the adolescent development process a balance between autonomy and interdependence must be negotiated in the family and with peers. This requires a great deal of self understanding. The family has varying degrees of autonomy and intimacy in relationships. This must change from adult/child to adult/adult levels of relating. Adolescents when developing their self awareness must make commitments to future aspirations and values with which to deal with adult roles and responsibilities. This commitment requires psychological distancing from their parents. Most adolescents look to their peer groups for opportunities to explore

these new personal values. When parents allow for the balancing of autonomy and intimacy they facilitate identity development. There may be a problem with peer pressure when an adolescent is not psychosocially mature. Low levels of family differentiation and identity awareness combined with peer group beliefs and values will be associated with high levels of substance use. Family stress or conflict inhibits identity development (Bartle, Sabatelli 1989). Poorly functional relationships are kept from developing by substance use and the use itself is seen as an autonomous act by a poorly defined identity.

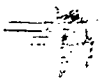
Bloch, Blook and Keyes (1988) conducted a ten year longitudinal study examining personality and family factors as antecedents of adolescent drug use. Self control is necessary for individuals to avoid beginning to use substances. Other contributors to adolescent substance use were low family expectations and lack of parental discipline or structure. Too much restrictive discipline, on the other hand, created feelings of rejection and also affected substance use. Poor communicating patterns and parent modeling were also seen as contributing factors (Lee, Goddard 1989).

Being raised in a household with an alcoholic parent is one of the most prevalent stressful situations a child can face. Compared to their peers children of alcoholics are more at risk for depression, lower self esteem, aggression

or acting out behaviors. They are also more prone to become alcoholics themselves (Rossu et al 1989). In order to help these children they must be identified, evaluated for intervention needs and tested during and after intervention to determine the results of emotional, cognitive and behavioral changes. They must continue to have supportive therapy for prolonged periods of time.

There are many adaptive tests which may be used for persons who use or persons close to individuals who use substances. These tests include the Michigan Alcoholism Screening Test (Seltzer et al 1975); Children of Alcoholics Screening Test (Jones 1983); behavioral checksheets such as those found in Appendix A; Cultural Affiliation checksheets; Self Perception Profile for Children (Harten 1985); Coping Srategies Inventory (Wills 1985); Children's Depression Inventory (Kovacs 1985); the A.M.L. Behavior Rating Scale (Cowen et al 1973); and self constructed program evaluation checksheets and questionnaires.

When parents use alcohol it is important to address their relationships and use and to relate this to the family dynamics. Jacobson et al (1989), having examined the literature on alcoholism in marital relationships determined that use indicated a family experiencing stress. The use allowed the release of aggression, established dominant patterns, and allowed for either exaggeration or restrictions in

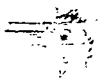


family members' behaviors. The use was seen as being a temporary solution to problems or a respite from stress. Some couples were seen as acting more positively while in the "wet" stage, with more communication and positive affect; however, some couples were more negative in their interactions.

The use of substances was a cyclical pattern between wet, dry and intermediate stages. There were cycles within the stages themselves. Alcoholic behavior differs for the person who drinks alone and the person who prefers to drink with others. Variables affect each individual or family group. Even the type of alcohol chosen affects behavior. Some forms facilitate more violent behavior in some individuals.

8. Recommendations and Conclusions

After examining the current literature several key elements appear to be essential in educating and counseling Native American populations. It must be remembered that they are culturally distinct groups living in areas which were not their homelands attempting to regain a traditional inner and outer balance in a world requiring specific skills for survival which are both social and cognitive in nature. They are badly in need of positive public relations due to the chauvinistic biased value system they have been measured



against. They are in need of learning the positive benefits of the society around them so that they may choose methods of dealing with their own communities in their own way.

It takes quality, trained, understanding personnel utilizing one interactive systemic approach to address areas in need of immediate attention. This approach is best handled by a case management system integrating existing programs and creating necessary new programs to address needs in a multidisciplinary way. These disciplines include Education, Medicine, Vocational Rehabilitation and Social/Behavioral counseling. It is necessary to list the resources available, to develop new options and to network for complete coverage.

For each individual who needs assistance internal and external sequences of events need to be determined. The external interactions need to be defined relating to the ecosystems of family, peers, community and exterior society.

Individual intervention may best be accomplished in eight areas:

1) Education: In the learning style best suited for that individual.

2) Skill building: Both socially and vocationally.

3) Recreation: This increase natural highs, releases tension, builds self esteem and group identity, promotes health.

4) Modeling: By providing appropriate role models and behavioral models individuals may learn to express themselves in better ways.

5) Support Groups: These may be peer, sport, stress management, problem solving and coping. They provide opportunities to practice new skills and experiences and provide the concept of not being alone.

6) Communication development: In all ecosystems.

7) Medical evaluations on a regular basis.

8) Counseling: To develop self awareness and to positively plan for future growth.

By working together, looking at the total picture, using interdisciplinary approaches, Native American communities can be returned to a balanced state.

Bibliography

A.C.L.D. Board of Directors (Sept. 22, 1984 meeting) (1985). "Definition of the Condition, Specific Learning Disabilities." A.C.L.D. Newsbriefs, p. 1, #158, Jan., Feb.

Ashabranner, B. (1984). To Live in Two Worlds: American Indian Youth Today. Dodd, Mead and Company, New York, New York.

Bartle, S.E.; Sabatelli, R.M.; (1989). "Family Systems Dynamics, Identity Development, and Adolescent Alcohol Use: Implications for Family Treatment." Family Relations, pp. 258-265, vol. 36.

Biller, E.F.; White, W.J. (1989). "Comparing Special Education and Vocational Rehabilitation in Serving Persons with Specific Learning Disabilities." Rehabilitation Counseling Bulletin, pp. 4-17, #1, September.

Blook, J; Blook, O.H.; Keyes S. (1988). "Longitudinally Foretelling Drug Use in Adolescence: Early Childhood Personality and Environmental Precursors." Child Development, pp. 336-355, vol. 59.

Bradshaw J. (1988). "Healing the Shame that Blinds You." Deerfield Beach: Health Communications.

Brisling, R.W. (Ed.) (1977). Cultural Learning: Concepts Application and Research, University Press, Honolulu, Hawaii.

Brown, D.S. (1989). "Workforce Composition in the Year 2000: Implications for Clients with Learning Disabilities." Rehabilitation Counseling Bulletin, pp. 80-85, vol. 33, #1, Sept.

Bruneau, O. (1985). "Self-Concept: A Comparison of Native American and Anglo Preschoolers." Psychology in the Schools, pp. 378-379, vol. 22.

Cartriedge, G. (1989). "Social Skills and Vocational Success for Workers with Learning Disabilities." Rehabilitation Counseling Bulletin, pp. 74-79, vol. 33, #1, September.

Center for Disease Control (1984). Seven Handbooks for Health Education: Decision Making, Bureau of Health Education and Health Promotion, Atlanta, Ga.

Christiansen, B.A.; Roehling, P.V.; Smith, G.T..; Goldman, M.S. (1989). "Using Alcohol expectancies to Predict Adolescent Drinking Behavior After One Year." Journal Counseling and Clinical Psychology, pp. 93-99, vol. 57, #1.

Coladaric, T. (1983). "High School Dropout Among Native American Americans." Journal of American Indian Education, pp. 15-22, vol. 23.

Cooper, J.R.; Bloom, F.E.; Roth, R.H. (1982). Biochemical Basis of Neuropharmacology, Oxford Press, New York, New York.

Cowen, E.L.; Door, D.; Clarfield, S.; Kreling, B.; McWilliams, S.A.; Pobracki, F.; Pratt, D.M.; Terrell, D.; Wilson, A. (1973). "The A.M.L.: A Quick Screening Device for Early Identification of School Maladaption." American Journal of Community Psychology, pp. 12-35, #1.

Ellis, E.S.; Graves, A.W. (1990). "Teaching Rural Students with Learning Disabilities: A Paraphrasing Strategy to Increase Comprehension of Main Ideas." Rural Special Education Quarterly, pp. 2-10, vol. 10, #2.

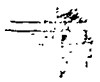
Fagan J.; Pabon E. (1990). "Contributions of Delinquency and Substance Use to School Dropout Among Inner City Youths." Youth and Society, pp. 306-354, vol. 21, #3.

Fox, C.L.; Forbing, S.E. (1991). "Overlapping Symptoms of Substance Abuse and Learning Handicaps Implications for Educators." Journal of Learning Disabilities, pp. 24-30, vol. 24, January.

Gabe, E.M.; Fuqua, D.; Hurlbert, G. (1984). "Use of the Self Directed Search with Native American High School Students." Journal of Counseling Psychology, pp. 584-587, vol. 31.

Gaeg, G. (1983). "Multi Ethnic Education: Historical Development and Future Prospects." Phi Delta Kappan, pp. 653-656, vol. 67.

Gilkeson, R. (1989). Marijuana Myths and Misconceptions [videotape series]. Coscob CT: Center for Drug Education and Brain Research.



Goodlab, J.I. (1983). "A Study of Schooling: Implications for School Improvement." Phi Delta Kappan, pp. 552-558, vol. 64.

Harter, S. (1985). Manual for the Self Perception Profile for Children, Unpublished Manuscript, University of Denver.

Hathaway, S.R.; McKirley, J.C. (1943). The Minnesota Multiphasic Personality Inventory, Minnesota, University of Minnesota Press.

Hawkins, J.D.; Catalano, R.F.; Gillmore, M.R.; Wells, E.A. (1989). "Skills Training for Drug Abusers: Generalization, Maintenance and Effects on Drug Use." Journal of Consulting and Clinical Psychology, pp. 559-563, vol. 57, #4.

Herring, R.D. (1989). "Counseling Native American Children." Implications for Elementary School Guidance and Counseling, pp. 272-281, vol. 23, April.

Hershenson, D.B. (1990). "A Theoretical Model for Rehabilitation Counseling." Rehabilitation Counseling Bulletin, pp. 268-279, vol. 33, #4, June.

Inhelder, B.; Piaget, J. (1964). The Early Growth of Logic in the Child, Routledge and Kegan Paul, London, England.

Jacobson, N.S.; Holtzworth-Monroe, A.; Schmaling, K.B. (1989). "Marital Therapy and Spouse Involvement in the Treatment of Depression, Agoraphobia and Alcoholism." Journal of Consulting and Clinical Psychology, pp. 5-10, vol. 57, #4.

Johnson, M.E.; Lashley, K.H. (1989). "Influence of Native American Cultural Commitments on Preferences for Counselor Ethnicity and Expectations about Counseling." Journal of Multicultural Counseling and Developing, pp. 113-122, July.

Jones, J.W. (1983). The Children of Alcoholics Screening Test Manual, Camelot, Chicago, Ill.

Kovacs, M. (1985). "The Children's Depression Inventory (CDI)." Psychopharmacology Bulletin, pp. 995-999, vol. 21.

Kunce, J.T.; Newton, R.M. (1989). "Normal and Psychopathological Personality Characteristics of Individuals in Alcohol Rehabilitation." Journal of Counseling Psychology, pp. 308-315, vol. 36, #3.

Larson, L.M.; Heppner, P.P. (1989). "Problem Solving Appraisal in an Alcoholic Population." Psychology, pp. 73-78, vol. 36, #1.

Lee, T.R.; Goddard, H.W. (1989). "Developing Family Relationship Skills to Prevent Substance Abuse Among High Risk Youth." Family Relations, pp. 301-305, vol. 38.

Lewis, R.A. (1989). "The Family and Addictions: An Introduction." Family Relations, pp. 254-257, vol. 38.

Loftin, J.D. (1989). "Anglo American Jurisprudence and the Native American Tribal Quest for Religious Freedom." American Indian Culture and Research Journal, pp. 1-52, vol. 13, #1.

Marias, C.J. (1989). "American Indian Academic Success: The Role of Indigenous Learning Strategies." Journal of American Indian Education, pp. 43-52, Special Issue August.

McCue, M. (1989). "The Role of Assessment in the Vocational Rehabilitation of Adults with Specific Learning Disabilities." Rehabilitation Counseling Bulletin, pp. 19-37, vol. 23, #1, Sept.

Michaels, C.A. (1989). "Employment: The Final Frontier - Issues and Practices for Persons with Learning Disabilities." Rehabilitation Counseling Bulletin, pp. 67-73, vol. 33, #1, Sept.

Mitchum, N.T. (1989). "Increasing Self-Esteem in Native American Children." Elementary School Guidance and Counseling, pp. 266-271, vol. 23, April.

Mohatt, G.V. (1989). "The Community as Informant or Collaborator." American Indian and Alaskan Native Mental Health Research, pp. 64-67, vol. 2, #3.

National Council on Alcoholism (1982). Facts on Teenage Drinking, Fox CL, Forbing, S.E. Ed., New York, New York.

Okwumabua, J.O.; Duregea, E.J. (1989). "A Test of the Ability of Native American Seventh Grade Students to

Learn and Apply a Four Step Decision Making Process." Journal of American Indian Education, pp. 14-23, vol. 28, #3.

Okwumabua, J.O.; Okwumabua, T.M.; Duryea, E.J. (1989). "An Investigation of Health Decision-Making Skills Among American Indian Adolescents." American Indian and Alaskan Native Mental Health Research, pp. 45-52, vol. 2, #3.

Rehabilitation Services Administration (1985). Program Policy Directive RSAPPD, Washington, D.C., #7, March 5.

Roosa, M.W.; Gensheimer, L.K.; Short, J.L.; Ayers, T.S.; Shell, R. (1989). " A Preventive Intervention for Children in Alcoholic Families: Results of a Piolet Study." Family Relations, pp. 295-305, #38.

enthal, D.A.; Gurney, R.M.; Moore, S.M. (1981). "From Trust to Intimacy: A New Inventory for Examining Erikson's Stages of Psychosocial Development." Journal of Youth and Adolescence, pp. 525-535, vol. 10.

Sattler, J.M. (1982). Assessment of Children's Intelligence and Special Abilities (2nd ed.). Allen and Bacon, Boston, Mass.

Selzer, M.L.; Venokur, A.; Rooijen, L.V. (1975). "A Self Administered Short Michigan Alcoholism Screening Test (SMAST)." Journal of Studies on Alcohol, pp. 117-132, vol. 31.

Simons, R.L.; Robertson, J.F. (1989). "The Impact of Parenting Factors, Deviant, Peers, and Coping Style Upon Adolescent Drug Use." Family Relations, pp. 273-281, vol. 38.

Soldier, L. (1985). "To Soar with Eagles: Enculturation and Acculturation of Indian Children." Childhood Education, pp. 185-191, vol. 61.

Svanum, S.; McAdoo, W.G. (1989). "Predicting Rapid Relapse Following Treatment for Chemical Dependance: A Matched Subject Design." Journal of Consulting and Clinical Psychology, pp. 222-226, vol. 57, #2.

Swisher, K.; Deyhle, D. (1989). "The Styles of Learning are Different, but the Teaching is Just the Same: Suggestions for Teachers of American Indian Youth." Journal of American Indian Education, pp. 1-14, Special Issue-Aug.

Sysmanski, E.M.; Dunn, C.; Parker, R.M. (1989). "Rehabilitation Counseling with Persons with Learning Disabilities, an Ecological Flamework." Rehabilitation Counseling Bulletin, pp. 38-53, vol. 33, #1, Sept.

Taricone, P.F.; Bordieri, J.E.; Salia, V.A. (1989). "Assessing Rehabilitative Needs of Clients in Treatment for Alcohol Abuse." Rehabilitative Counseling Bulletin, pp. 324-332, vol. 32, #4, June.

Tennant Jr., F.S. (1985). Primer on Neurochemistry of Drug Dependency, Veract, West Covina, California.

Tennant Jr., F.S. (1987). "The Inadequate Plasma Concentration in Some High Dose Methadone Maintenance Patients." American Journal of Psychiatry, pp. 1349-1350, vol. 144, #10.

Tooker, E. (Eds.) (1983). The Development of Political Organization in Native North America, The American Ethnological Society, Washington, D.C.

U.S. Office of Education (1977). "Assistance to States for Education of Handicapped Children: Procedure for Evaluating Specific Learning Disabilities." Federal Register, #4265082-65085, December 29.

Volk, R.L.; Edwards, D.W.; Lewis, R.A.; Sprenkle, D.H. (1989). "Family Systems of Adolescent Substance Abusers." Family Relations, pp. 266-272, vol. 38.

Wills, T.A. (1985). "Stress Coping and Tobacco and Alcohol Use in Early Adolescence." In Stiffman S. (Ed.) Coping and Substance Use, pp. 67-94, Academic Press, New York, New York.

Youngman, G.; Sabonge, M. (1974). "Counseling the American Indian Child." Elementary School Guidance and Counseling, pp. 273-277, vol. 9.

Appendix A
Charts and Checksheets

Table 1 - Family Profile Questionnaire

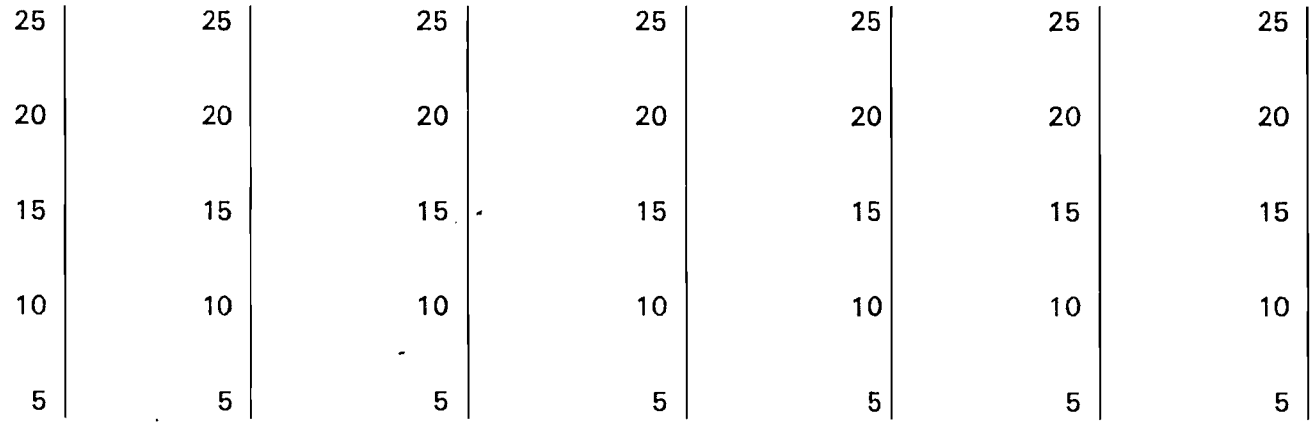
1 Almost Never	2 Once in A While	3 Sometimes	4 Frequently	5 Almost Always

Describe how you see the way your family actually is:

___ 1. We enjoy doing things together.
___ 2. We all help make the decisions in our family.
___ 3. We are proud of our family.
___ 4. We think the same things are important.
___ 5. We compliment each other.
___ 6. We can say what we really feel.
___ 7. We know we can handle the problems that come up.
___ 8. We share interests and hobbies.
___ 9. When there is a problem, children's suggestions are followed.
___ 10. We respect one another.
___ 11. We have similar values and beliefs.
___ 12. We do nice things for each other.
___ 13. We really listen to each other.
___ 14. We can count on each other.
___ 15. Our family often does fun things together.
___ 16. Children have a say in the rules and discipline.
___ 17. We stick together as a family.
___ 18. We agree about what is right and wrong.
___ 19. We express love for each other.
___ 20. We believe it's important to understand each other's feelings.
___ 21. Things usually work out for the best in our family.
___ 22. Togetherness is very important in our family.
___ 23. Chores are divided up fairly in our family.
___ 24. We have traditions that we carry on.
___ 25. We agree about what really matters in life.
___ 26. We feel very close to each other.
___ 27. We can talk about things without arguing.
___ 28. We have friends and relatives we can count on.
___ 29. It is easy for us to think of things to do together.
___ 30. Our family discusses problems until we find a solution that's good for everyone.
___ 31. We are proud of our family's history.
___ 32. It's important to do what is right in our family.
___ 33. We care about how others in the family feel.
___ 34. We enjoy talking about things together.
___ 35. We look forward to what the future will bring.

Table 2 - Family Profile Graph

Write the totals that each family member had for the seven key areas of the Family Profile Scoresheet, below the column for each key area in the graph below. Mark each family member's total score in a different color on the graph. Add up the family members' scores for each area and divide by the number who took the questionnaire. This is your overall family score on each of the seven areas. Mark these scores on the graph in a different color also. Connect the different colored dots with lines of the same color. This shows the pattern for each person in your family and for the family as a whole.



Family Members' Names	Family Fun	Family Decisions	Family Pride	Family Values	Family Caring	Family Confidence	Family Communications
_____	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___
Total	___	___	___	___	___	___	___
Averages	___	___	___	___	___	___	___

Table 3
Cognitive Behavioral-Emotional Characteristics of S.L.D.

I. Sensory-Perceptual Deficits
   1. Visual Perception
      A. Figure-Ground
      B. Sequencing
      C. Discrimination
      D. Scanning
      E. Depth Perception
      F. Form Constancy
   2. Auditory Perception
      A. Figure-Ground
      B. Sequencing
      C. Discrimination

II. Motor Functioning Problems
   1. Speed/Rate
   2. Coordination
   3. Tactual Motor:
   4. Auditory Motor:
   5. Visual Motor:
   6. Apraxia

III. Higher Level Cognitive Deficits
   1. Attention and Concentration
   2. Memory
   3. Organization of Thinking and Sequential Logic
   4. Critical Thinking/Insight
   5. Flexibility/Perseveration
   6. Understanding Relationship and Associations
   7. Generalization
   8. Prioritization
   9. Problem Solving and Systematic Planning
   10. Slow Response (Latency)
   11. Impulsivity and Disinhibition
   12. Frustration Tolerance

IV. Language Skill Deficits
   1. Expressive Language: Spoken Communication
      A. Tone/Volume
      B. Relevance
   2. Expressive Language: Written Communication
   3. Receptive Language: Hearing
   4. Receptive Language: Written (Reading)
   5. Nonverbal Language
      A. Kinesics
      B. Proxemics
      C. Vocalic Communication
      D. Artifactual Communication

Table 3 (continued)

V. Spatial-Relations Problems
   1. Directional Sense
   2. Time Sense
   3. Visuoconstruction
   4. Spatial Orientation
   5. Right-Left Confusion
   6. Visual Imagery
   7. Rotations
   8. Body Image

VI. Academic Problems
   1. Reading Dyslexia:
   2. Arithmetic Dyscalculia:
   3. Writing Dysgraphia:
   4. Spelling Dyspraxia:

VII. Psycho-Social Difficulties
   1. Impulsivity
   2. Poor Frustration Tolerance
   3. Explosiveness
   4. Poor Social Perception
   5. Avoidance/Covering
   6. Socially Inept
   7. Unpredictable
   8. Irritable
   9. Poor Self-Image
   10. Poor Nonverbal Social Skills
   11. Literal, Humorless, Gullible
   12. Lability and Inappropriate Affect
   13. Withdrawn
   14. Catastrophic Response
   15. Disinhibition
   16. Depressed
   17. Anxious
   18. Inability to Delay Gratification

Table 4
At Risk Behavioral Checklist

The following behaviors have been found to predict problems in children and adolescents. Please check all that you have observed directly.

Student _____ Grade _____
Person referring _____ Date _____
Subject or Location _____ Time _____

Grades
___ Grades are dropping
___ Academic failure
___ Does not complete assignments
___ Apathetic, lacks motivation
___ Inconsistent daily work
___ Inconsistent test grades

School Attendance
___ Truancy
___ Excessive abseenteism
___ Tardiness
___ Absent from class, but in building
___ Suspension
___ Frequent nurse or counselor visits

Classroom Deportment
___ Change in class participation
___ Change in student-teacher rapport
___ Falls asleep in class
___ Disrupts classroom learning
___ Cheats on academic tasks
___ Defiance of teacher's rules
___ Project blame onto others
___ Abusive language or behavior
___ Dramatic attention seeking
___ Obscene language or gestures
___ Sexually uninhibited
___ Fighting
___ Destructive

Please Identify Student's Strengths:

___ creative
___ sense of humor
___ confidence
___ social skills
___ academic skills
___ cooperative
___ artistic
___ other: _____

___ enthusiastic
___ good motivation
___ physical strength
___ good coordination
___ highly verbal
___ compassionate
___ leadership skills

Other Behavior
___ Hyperactivity
___ Appears sullen/depressed
___ Mood swings
___ Irritable
___ Extreme negativism
___ Easily distracted
___ Easily frustrated
___ Hostile
___ Jumpy if touched
___ Withdrawn
___ Disoriented to time
___ Defensive
___ Memory problems
___ Inappropriate responses
___ Takes excessive risks
___ Cigarette smoking
___ Talks freely about drug use
___ Change in friends
___ Loitering in parking lot

Physical Appearance
___ Appears drowsy
___ Poor motor coordination
___ Unkempt clothing
___ Poor personal hygiene
___ Clothes advertising substance use
___ Drastic change in appearance
___ Weight fluctuations
___ Staggering or stumbling
___ Dilated pupils
___ Glassy or bloodshot eyes
___ Wears dark glasses
___ Speech garbled/slurred/incoherent
___ Difficulty breathing
___ Constant "cold" or stuffiness
___ Redness/irritation in nasal area
___ Increased heart rate
___ Vomiting
___ Physical injuries/bruises/cuts
___ Chronic cough
___ Chronic fatigue
___ Odor of alcohol
___ Odor of cigarettes
___ Odor of burning substance

___ Other Behavior Observed _____

Have you ever referred this student for similar behavior before? ___ yes ___ no
If yes, when? _____